



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Donald M. McPhaul, M.D.

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-16-3120-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The service provided for EMG/NCV includes an office consultation for this date of service. These CPT Codes are not to be bundled per the fee guidelines. Per the attached report an office consult was performed as part of making an accurate diagnosis for this examinee with regards to the performance of the testing and used in making a final determination. The examination is correlated with clinical findings performed as part of the office consultation. It is documented and billed appropriately."

Amount in Dispute: \$285.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Regarding the A4556, supplies usually used to complete the nerve conduction study should not be billed separately."

Regarding 99204. Documentation does not support the level billed. Provider must document all three of the following: Comprehensive history, comprehensive exam, and moderate complexity decision making. None of these is met."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 21, 2015	Evaluation & Management, new patient (99204)	\$260.90	\$0.00
October 21, 2015	Needle Electromyography (95886)	\$0.00	\$0.00
October 21, 2015	Nerve Conduction Studies; 7-8 studies (95910)	\$0.00	\$0.00
October 21, 2015	Electrodes (A4556)	\$25.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 15 – Payer deems the information submitted does not support this level of service.
 - P12
 - Z710

Issues

1. What are the rules that determine reimbursement for the disputed services?
2. Are New Hampshire Insurance Company's reasons for denial of payment for procedure code 99204 supported?
3. Are New Hampshire Insurance Company's reasons for denial of payment for procedure code A4556 supported?

Findings

1. Donald M. McPhaul, M.D. is seeking reimbursement of \$285.90 for procedure codes 99204 and A4556. Dr. McPhaul included procedure codes 95886 and 95910 on the Medical Fee Dispute Resolution Request (DWC060), but is seeking \$0.00 for these procedures; consequently they will not be considered in this dispute. Reimbursement for the disputed codes is subject to the fee guidelines for professional medical services found in 28 Texas Administrative Code §134.203(b)(1), which states, in pertinent part:

for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...

2. New Hampshire Insurance Company denied procedure code 99204 with claim adjustment reason code 5213 – "SERVICES ARE NOT PAYABLE AS DOCUMENTATION DOES NOT SUPPORT THE SERVICES RENDERED." The American Medical Association (AMA) CPT code description for 99204 is:

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: **A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity** [emphasis added]. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

The 1997 Documentation Guidelines for Evaluation & Management Services, published by the Centers for Medicare and Medicaid Services (CMS) found at <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf> puts forth the requirements to meet the AMA CPT code description presented. The division will review the submitted documentation to determine if the requirements, as outlined by the 1997 Documentation Guidelines, were met.

Documentation of a Comprehensive History:

	Requirement	Guideline Elements	Documented Elements	Requirement Met?
Chief Complaint	Statement describing the symptom, etc.	1 statement	"The above examinee was referred for Electromyography Testing (EMG/NCV)... The examinee presents today with complaints to the following areas: NO CURRENT COMPLAINTS"	Yes
Extended HPI	At least four elements of the HPI.	Location	x	Yes
		Quality	x	
		Severity	x	
		Duration	x	
		Timing	x	
		Context	x	
		Modifying Factors	x	
		Assoc. Signs/Symptoms		
Complete ROS	At least ten organ systems.	Constitutional		No
		Eyes		
		ENT		
		Cardio./Vasc.		
		Respiratory		
		GI		
		GU		
		Musculoskeletal	x	
		Integumentary		
		Neurological	x	
		Psychological		
		Endocrin		
		Hem./Lymph.		
		Allergy/Immun.		
		All Others Neg.		
Complete PFSH	At least one specific item from each of the three history areas.	Past	x	Yes
		Family	x	
		Social	x	

The Guidelines state, "To qualify for a given type of history all three elements in the table must be met."

Submitted documentation supports the presence of a chief complaint and an extended history. Because the provider documented only two systems, a complete review of systems was not supported. The provider documented three areas of history; therefore, a complete PFSH was supported for a new patient office visit.

The division finds that the submitted documentation does not support a Comprehensive Medical History, which is required for procedure code 99204.

Documentation of a Comprehensive Examination:

The 1997 Documentation Guidelines requires a comprehensive examination to include "a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)." Review of the submitted report finds that the documented examination most closely supports a single organ system examination for the musculoskeletal system. A "comprehensive examination [for a single organ system] ...should include performance of all elements [of the Musculoskeletal Examination table]."

System/Body Area	Guideline Elements of Examination	Documented Elements
Cardiovascular	Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)	
Lymphatic	Palpation of lymph nodes in neck, axillae, groin, and/or other location	
Skin	Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café-au-lait spots, ulcers) in four of the following six areas: 1) head and neck, 2) trunk, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, 6) left lower extremity. Note: For the comprehensive level, the examination of all four anatomic areas must be performed and documented...	
Neurological/ Psychiatric	Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, ...)	x
	Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)	x
	Examination of sensation (e.g., by touch, pin, vibration, proprioception)	x
	Orientation to time, place and person	
	Mood and affect (e.g., depression, anxiety, agitation)	x
Constitutional	Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)	x
	General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)	x
Musculoskeletal	Examination of gait and station	x
	Examination of joint(s), bone(s), and muscle(s)/tendon(s) of four of the following six areas: 1) head and neck; 2) spine, ribs, and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity... Note: For the comprehensive level of examination, all four elements identified by a bullet must be performed and documented for each of four anatomic areas...	
	Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions	x
	Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation or contracture	
	Assessment of stability with notation of any dislocation (luxation), subluxation or laxity	
	Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements	x

A review of the submitted report finds that six of the required elements were not sufficiently documented. Therefore, submitted documentation does not support a Comprehensive Examination, which is required for procedure code 99204.

Documentation of Decision Making of Moderate Complexity:

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The submitted report is considered for the presence of the following elements:

➤ *Number of diagnoses or treatment options*

Problem(s) Status	Number	Documented
Self-limited or minor (stable, improved or worsening)	Max 2	
Est. problem (to examiner); stable, improved		
Est. problem (to examiner); worsening		
New problem (to examiner); no additional workup planned	Max 1	x
New problem (to examiner); additional workup planned		

Review of the submitted documentation finds that a new problem to the examiner was presented with no additional workup planned, meeting the documentation requirements of moderate complexity. The performance of the electromyography and nerve conduction study was not considered, as the decision to perform this testing was the purpose of the referral and not a result of the examination. Documentation supports that this element was met.

➤ *Amount and/or complexity of data to be reviewed*

Reviewed Data	Documented
Review and/or order of clinical lab tests	
Review and/or order of tests in the radiology section of CPT	
Review and/or order of tests in the medicine section of CPT	
Discussion of test results with the performing physician	
Decision to obtain old records and/or obtain history from someone other than patient	
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	x
Independent visualization of image, tracing or specimen itself (not simply review of report)	

Review of the documentation finds that the requestor reviewed and summarized the relevant findings from other providers. The documentation does not support that this element met the criteria for moderate complexity of data reviewed.

➤ *Risk of complications and/or morbidity or mortality*

Review of the submitted documentation finds that presenting problems include one acute injury and no ordered procedures or management options selected, which presents a moderate level of risk, per the Table of Risk found in the 1997 Documentation Guidelines. "The highest level of risk in any one category...determines the overall risk." The documentation supports that this element met the criteria for moderate risk.

The 1997 Documentation Guidelines requires that "To qualify for a given type of decision making, **two of the three elements ... must be either met or exceeded.**" A review of the submitted documentation supports that this component of procedure Code 99204 was met.

Because only one component of CPT Code 99204 was met, the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203. The insurance carrier's denial reason is supported. No additional reimbursement is recommended for this service.

3. New Hampshire Insurance Company denied procedure code A4556 with claim adjustment reason code P12 – “WORKERS’ COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.” Medicare policy finds that CPT Code A4556 is a Bundled/Excluded code, which means,

There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.--If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.)--If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

The Medicare Benefit Policy Manual, Chapter 15 §60.1 states, “Incident to a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.” The electrodes are incident to the physician services furnished the same day, therefore, they are bundled in those services. The insurance carrier’s denial reason is supported. No additional reimbursement is recommended for this service.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	Laurie Garnes	December 2, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.